

**Memorandum**

MAR 8 2001

Date

From

Michael Mangano
Michael F. Mangano
Acting Inspector General

Subject

Review of Medicaid Enhanced Payments to Public Providers and the Use of
Intergovernmental Transfers by the Alabama State Medicaid Agency (A-04-00-02165)

To

Michael McMullan
Acting Principal Deputy Administrator
Health Care Financing Administration

Attached are two copies of our final report entitled, "Review of Medicaid Enhanced Payments to Public Providers and the Use of Intergovernmental Transfers by the Alabama State Medicaid Agency." This is one in a series of reports on enhanced payments made in six States. At the completion of all the audits, we will issue a summary report to the Health Care Financing Administration (HCFA) that will consolidate the results of our reviews in the six States and will include additional recommendations addressing enhanced payments financed through the intergovernmental transfer (IGT) process.

The objectives of our review were to analyze the use of enhanced payments and to evaluate the financial impact of IGTs on the Medicaid program. We found that the Medicaid enhanced payments to rural government owned hospital based nursing facilities were not based on the actual cost of providing services to Medicaid beneficiaries, or directly related to increasing the quality of care provided by public facilities. Typically, such a relationship is inherent in federally funded health care programs.

We also found that a large portion of the enhanced payments was not being retained by the nursing facilities to provide services to Medicaid beneficiaries. Instead, 96.5 percent of the enhanced payments was transferred back to the State Medicaid agency for other uses. For Fiscal Years (FY) 1999 and 2000, Alabama made enhanced payments to nursing facilities totaling about \$83.5 million (Federal share about \$58.5 million). Subsequent to the initial payment by the State agency, approximately \$80.5 million was returned to the State and only about \$3 million was retained by the facilities.

Because the payments were returned to the State agency, it appears that the State did not incur an expenditure (for 96.5 percent of the enhanced payments) for which Federal matching funds may be claimed. This condition draws into question whether the amounts paid back to the State agency constitute a refund required to be reported as other collections and consequently offset against expenditures on the HCFA Form 64. As is, the State agency developed a mechanism to obtain additional Federal Medicaid funds without committing its share of required matching funds. As a result of this mechanism, we estimate that the Federal share of nursing home expenditures in Alabama increased from the approved Federal matching rate of about 70 percent to about 78 percent, thus effectively reducing the State share by 8 percent.

We found that if regulations were changed to include a separate aggregate upper limit applicable to payments made only to local government owned facilities, the amount of funds available to Alabama for enhanced payments to public providers would be significantly reduced. Thus, Federal Medicaid funds that public providers are able to transfer to the State for other uses would be limited. As previously stated, the combined enhanced payment funding pools for FYs 1999 and 2000 totaled approximately \$83.5 million. A change in regulations, as discussed by HCFA, would have reduced the funding pool to about \$4.5 million..

We also noted the potentially significant financial impact of using resource utilization groups (RUGs)¹ to calculate the Medicare upper payment limit in determining a State's enhancement payment pool. Alabama used cost report data to determine its Medicare upper payment limit and calculated funding pools of \$39.5 million for FY 1999 and \$44 million for FY 2000. However, for comparison, the State completed three different funding pool calculations using RUGs to estimate the Medicare upper payment limit. The estimates ranged from \$129 million to \$341 million.

In our draft report, we recommended that HCFA move as quickly as possible to issue regulatory changes involving the upper payment limit calculations. We also recommended that HCFA take additional action to ensure that claims for enhanced payments to Alabama's county-owned facilities are based on financial need and paid directly to the targeted nursing facilities for direct health care services for Medicaid residents. In addition, we recommended that HCFA define and develop definitive and consistent guidelines for calculating a reasonable Medicare upper payment limit pursuant to the economy and efficiency provisions at section 1902 (a) (30) of the Social Security Act.

In a written reply to our draft report, HCFA generally concurred with our recommendations and believes that recently published upper payment limit revisions will significantly eliminate excessive enhanced payments. The HCFA noted that it published, on October 10, 2000, proposed regulations to close the loophole in Medicaid regulations that costs Federal taxpayers billions of dollars without commensurate increases in coverage or improvements in the care provided to Medicaid beneficiaries. The HCFA also agreed in principle with our second recommendation to require that enhanced payments be need based and paid directly to the targeted nursing facilities for health care services of Medicaid residents. However, HCFA believed that a new regulation would be required which would force it to divert resources away from its current upper payment limit reform initiative.

Finally, HCFA concurred with our recommendation that it address the method of calculating the Medicare upper payment limit. However, HCFA believes that its existing State plan review process is adequate for ensuring that upper payment limit calculations are reasonable.

¹ As part of the Medicare prospective payment system for skilled nursing facilities (SNF), RUGs are used to determine the payment for SNF services. The RUGs can be used by States to calculate their upper payment limit.

The HCFA believes that regardless of whether a State uses Medicare prospective payment or cost-based systems to compute the Medicare upper payment limit, creating a separate upper payment limit for local government owned providers will significantly eliminate excessive payments.

We commend HCFA for taking action to change the upper payment limit regulations. On January 12, 2001, HCFA issued revisions to the upper payment limit regulations. The regulations included several transition periods, one of which applied to Alabama. In Alabama, we estimate savings to the Federal Government of about \$44.2 million during the transition period ending October 1, 2005. Once the regulatory changes are fully implemented (i.e., the transition period is passed), we estimate savings to the Federal Government of about \$29.5 million annually, totaling a savings of about \$147.5 million over 5 years.

We continue to believe that HCFA needs to define and develop definitive and consistent guidelines for calculating a reasonable Medicare upper payment limit. Any proposed methodology should be cost based and not contemplate the use of RUGs in the estimates. We also believe that HCFA should require enhanced payments be based on financial need and paid directly to the targeted facilities for direct health care services for Medicaid residents.

Please advise us within 60 days on actions taken or planned on our recommendations. If you have any questions, please contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104.

To facilitate identification, please refer to Common Identification Number A-04-00-02165 in all correspondence relating to this report.

Attachment

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF MEDICAID
ENHANCED PAYMENTS TO PUBLIC
PROVIDERS AND THE USE
OF INTERGOVERNMENTAL
TRANSFERS BY THE ALABAMA STATE
MEDICAID AGENCY**



**MARCH 2001
A-04-00-02165**

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Date MAR 8 2001
Michael Mangano
From Michael F. Mangano
Acting Inspector General

Subject Review of Medicaid Enhanced Payments to Public Providers and the Use of Intergovernmental Transfers by the Alabama State Medicaid Agency (A-04-00-02165)

To Michael McMullan
Acting Principal Deputy Administrator
Health Care Financing Administration

This final report provides the results of our review of Medicaid enhanced payments to public providers and the use of intergovernmental transfers (IGT) by the State of Alabama and local governments within Alabama. This is one in a series of reports on enhanced payments made in six States. At the completion of all the audits, we will issue a summary report to the Health Care Financing Administration (HCFA) that will consolidate the results of our reviews in the six States and will include additional recommendations addressing enhanced payments financed through the IGT process.

The objectives of our review were to analyze the use of enhanced payments and to evaluate the financial impact of IGTs on the Medicaid program. This report only includes information on Medicaid enhanced payment transactions resulting from the upper payment limit calculations. These enhanced payments are separate and apart from the basic payment rates for Medicaid providers. The basic Medicaid payments were not included as part of our review.

We found that the Medicaid enhanced payments to rural government owned hospital based nursing facilities were not based on the actual cost of providing services to Medicaid beneficiaries, or directly related to increasing the quality of care provided by public facilities. Typically, such a relationship is inherent in Federally funded health care programs.

We also found that a large portion of the enhanced payments was not being retained by the nursing facilities to provide services to Medicaid beneficiaries. Instead, 96.5 percent of the enhanced payments was transferred back to the State Medicaid agency for other uses. For Fiscal Years (FY) 1999 and 2000, Alabama made enhanced payments to nursing facilities totaling about \$83.5 million (Federal share about \$58.5 million). Subsequent to the initial payment by the State agency, approximately \$80.5 million was returned to the State and only about \$3 million was retained by the facilities.

Because the payments were returned to the State agency, it appears that the State did not incur an expenditure (for 96.5 percent of the enhanced payments) for which Federal matching funds may be claimed. This condition draws into question whether the amounts paid back to the State agency constitute a refund required to be reported as other collections

and consequently offset against expenditures on HCFA Form 64. As is, the State agency developed a mechanism to obtain additional Federal Medicaid funds without committing its share of required matching funds. As a result of this mechanism, we estimate that the Federal share of nursing home expenditures in Alabama increased from the approved Federal matching rate of about 70 percent to about 78 percent, thus effectively reducing the State share by 8 percent.

We found that if regulations were changed to include a separate aggregate upper limit applicable to payments made to local government owned facilities, the amount of funds available to Alabama for enhanced payments to public providers would be significantly reduced. Thus, Federal Medicaid funds that public providers are able to transfer to the State for other uses would be limited. As previously stated, the combined enhanced payment funding pools for FYs 1999 and 2000 totaled approximately \$83.5 million. A change in regulations, as discussed by HCFA, would have reduced the funding pool to about \$4.5 million.

Finally, we noted the potentially significant financial impact of using resource utilization groups (RUGs)¹ to calculate the Medicare upper payment limit in determining a State's enhancement payment pool. Alabama used cost report data to determine its Medicare upper payment limit and calculated funding pools of \$39.5 million for FY 1999 and \$44 million for FY 2000. However, for comparison, the State completed three different funding pool calculations using RUGs to estimate the Medicare upper payment limit. The estimates ranged from \$129 million to \$341 million.

We did not review the reasonableness of the estimates or the appropriateness of the RUGs used in the estimates because the State did not use them. However, estimates using RUGs are staggering in comparison to actual pools calculated using cost report data.

In our draft report, we recommended that HCFA move as quickly as possible to issue regulatory changes involving the upper payment limit calculations. We also recommended that HCFA take additional action to ensure that claims for enhanced payments to Alabama's county-owned facilities are based on financial need and paid directly to the targeted nursing facilities for direct health care services for Medicaid residents. In addition, we recommended that HCFA define and develop definitive and consistent guidelines for calculating a reasonable Medicare upper payment limit pursuant to the economy and efficiency provisions at section 1902 (a) (30) of the Social Security Act (the Act).

In a written reply to our draft report, HCFA generally concurred with our recommendations and believes that recently published upper payment limit revisions will significantly

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eliminate excessive enhanced payments. The HCFA noted that it published, on October 10, 2000, proposed regulations to close the loophole in Medicaid regulations that costs Federal taxpayers billions of dollars without commensurate increases in coverage or improvements in the care provided to Medicaid beneficiaries. The HCFA also agreed in principle with our second recommendation to require that enhanced payments be need based and paid directly to the targeted nursing facilities for health care services of Medicaid residents. However, HCFA believed that a new regulation would be required which would force it to divert resources away from its current upper payment limit reform initiative.

Finally, HCFA concurred with our recommendation that it address the method of calculating the Medicare upper payment limit. However, HCFA believes that its existing State plan review process is adequate for ensuring that upper payment limit calculations are reasonable. The HCFA believes that regardless of whether a State uses Medicare prospective payment or cost-based systems to compute the Medicare upper payment limit, creating a separate upper payment limit for local government owned providers will significantly eliminate excessive payments. The HCFA's response is included in its entirety as **APPENDIX A** to this report.

We commend HCFA for taking action. On January 12, 2001, HCFA issued revisions to the upper payment limit regulations. The regulations included several transition periods, one of which applied to Alabama. During the transition applicable to Alabama, the financial impact of the new regulations will be gradually phased in and become fully effective on October 1, 2005. In essence, the transition period allows the State of Alabama to claim the full upper payment limit calculated under the old regulations for the years 2001 and 2002, and gradually reduces the State's claim from 2003 through 2005, after which time the allowable payments will be as calculated under the new regulation.

In Alabama, we estimate savings to the Federal Government of about \$44.2 million during the transition period. Once the regulatory changes are fully implemented (i.e., the transition period is passed), we estimate savings to the Federal Government of about \$29.5 million annually, totaling a savings of about \$147.5 million over 5 years (see **APPENDIX B** for additional details). We, therefore, recommend that HCFA take action to ensure that Alabama complies with the phase-in of the revised regulations.

Additionally, we continue to believe that HCFA needs to define and develop definitive and consistent guidelines for calculating a reasonable Medicare upper payment limit pursuant to the economy and efficiency provisions at section 1902 (a) (30) of the Act. We believe that any proposed methodology should be cost based and not contemplate the use of RUGs in the estimates.

We also provided a copy of our draft report to the State agency and offered the State agency the opportunity to provide written comments to the facts presented in the report. The State agency did not provide any comments to the report.

BACKGROUND

Title XIX of the Act authorizes Federal grants to States for Medicaid programs that provide medical assistance to needy persons. Each State Medicaid program is administered by the State in accordance with an approved State plan. While the State has considerable flexibility in designing its State plan and operating its Medicaid program, it must comply with broad Federal requirements. The Medicaid programs are administered by the States but are jointly financed by the Federal and State governments. States incur expenditures for medical assistance payments to medical providers who furnish care and services to Medicaid eligible individuals. The Federal Government pays its share of medical assistance expenditures to a State according to a defined formula which yields the Federal medical assistance percentage (FMAP).

State Medicaid programs have flexibility in determining payment rates for Medicaid providers within their State. The HCFA allows State Medicaid agencies to pay different rates to the same class of providers as long as the payments, in aggregate, do not exceed the upper payment limits (what Medicare would have paid for the services). Under Federal regulations in effect during our review, the general rule regarding upper payment limits states that aggregate payments to each group of health care facilities, such as nursing facilities or hospitals, may not exceed the amount that can be reasonably estimated would have been paid under Medicare payment principles. This aggregate payment limit applies to all facilities in the State (private, State operated, and city/county operated). Also, there was a separate aggregate payment limit that applied only to State operated facilities. Because there was no separate aggregate limit that applied to local government operated facilities, these types of facilities were grouped with all other facilities when calculating aggregate upper payment limits. This allowed the State Medicaid agency to make enhanced Medicaid payments to city and county-owned facilities without violating the upper payment limit regulations. These enhanced payments are separate and apart from the basic Medicaid payments made to facilities that provide services to Medicaid-eligible individuals. Federal financial participation is not available for State expenditures that exceed the applicable upper payment limits.

SCOPE AND METHODOLOGY

The objectives of our review were to analyze the use of Medicaid enhanced payments to public providers and to evaluate the financial impact of IGTs on the Medicaid program. Our audit covered enhanced payments made to public providers in Alabama beginning September 1, 1999 through May 31, 2000. We attempted to determine the accuracy of the funding pool calculated by the State Medicaid agency for distribution to public providers and to track the dollars that were transferred between State and local governments.

To accomplish our objectives, we met with HCFA regional office staff and discussed their role and reviewed their records pertaining to Alabama's Medicaid program. We conducted a

review at the State Medicaid agency, interviewed key personnel, and reviewed applicable records supporting the funding pool calculations, enhanced payments, and IGTs. We also selected two county owned facilities that received enhanced payments to determine how the enhanced payments were used. At these facilities, we interviewed key personnel and reviewed their financial records supporting their cash flow.

Our review was conducted in accordance with generally accepted government auditing standards. The review was conducted from June through August 2000. We performed field work at the State agency in Montgomery, Alabama, and at two cities where the county owned nursing facilities were located.

RESULTS

Contrary to the spirit of the State-Federal matching requirements of the Medicaid program, the State Medicaid agency used enhanced payments as a means of obtaining millions of dollars of Federal funding over and above reasonable funding guidelines. In effect, the State agency developed a mechanism to obtain additional Federal Medicaid funds without committing its share of required matching funds. As a result of this mechanism, we estimate that the Federal share of nursing home expenditures increased from about 70 percent to about 78 percent, thus effectively reducing the State's share by 8 percent.

Although the additional funds, in the form of enhanced payments, were initially distributed to certain Medicaid providers, giving the appearance that the funds were to be used to provide direct medical services, we found that a large portion of these funds was not retained by the providers. Instead, the vast majority of the funds was refunded to the State Medicaid agency for other uses.

We also found that there was no correlation between the enhanced payments made to these providers and their actual cost of providing services to Medicaid beneficiaries. The enhanced payments made to the recipient facilities far exceeded their total costs.

We found that if regulations were changed to include a separate aggregate upper payment limit applicable to local government owned facilities, Medicaid funds available to Alabama for enhanced payments to public providers would be significantly reduced. A change in regulations, if applicable to FYs 1999 and 2000, would have reduced Alabama's enhanced payment pools from about \$83.5 million to about \$4.5 million, a total reduction of about \$79 million. For FY 2000 alone, the payments would have been reduced from about \$44 million to about \$1.9 million, a reduction of about \$42.1 million.

Additionally, we understand that HCFA allows State agencies to use RUGs to calculate the Medicare upper payment limit in determining their enhanced payment pools. Had Alabama

used RUGs in its FY 1999 or 2000 calculations, the State estimates that it would have received anywhere from \$129 million to \$341 million per year, depending on the methodology used. This range is in comparison to the \$39.5 million (FY 1999) and \$44 million (FY 2000) annual amounts calculated based on cost report data. We continue to believe that HCFA needs to define and develop a consistent means of determining how the Medicare upper payment limit should be calculated and that any proposed methodology should exclude the usage of RUGs.

The following sections provide more details on the results of our review.

ENHANCED PAYMENTS NOT BASED ON RECIPIENT FACILITY COSTS

We could not find any relationship between the amount of enhanced payments made to the recipient facilities and their actual costs of providing medical services. Typically, such a relationship is inherent in Federally funded health care programs. For FYs 1999 and 2000, the State agency calculated funding pools totaling about \$83.5 million based on over 200 nursing facilities in Alabama. This \$83.5 million was then allocated to nine recipient facilities considered eligible under the State's plan. By comparison, the total operating costs of these nine facilities for 2 years was only about \$50 million, of which an estimated \$43 million was reimbursed through Medicaid per diem payments.

Funding Methodology

The State agency received an approved State Plan Amendment (SPA) from HCFA, effective September 1, 1999, allowing for the creation of a funding pool to increase reimbursement to rural government owned hospital based nursing facilities. The funding pool was calculated by computing the difference between the Medicare upper payment limit (based on Medicare cost principles) and the allowable Medicaid payments for each facility in the State. The combined total of the differences for all facilities in the State represents the funding pool amount. The SPA further called for the total pool to be divided among the eligible rural government owned hospital based nursing facilities based on the proportionate number of Medicaid beneficiary days. The State agency made the payments on a monthly basis. Once each eligible facility (nine in this case) received its enhanced payment (Federal and State share), the majority of the funds were transferred back to the State.

No Relationship to Costs or Quality of Care

We found that the FY 1999 and 2000 funding pools were calculated in accordance with the requirements of the SPA and were based on Medicare cost principles. According to the SPA, the Medicare upper payment limit was based on June 30 (1997 and 1998) Medicaid cost report data. The funding pools for FYs 1999 and 2000 were \$39.5 million and \$44 million, respectively (totaling \$83.5 million).

While the calculation of the overall funding pool was in accordance with existing guidelines, the distribution of the pool bears no relationship to the cost of providing services to Medicaid beneficiaries. The total costs for the nine facilities receiving the payments were approximately \$50 million over 2 years. We estimated the Medicaid per diem payments to these facilities to be about \$43 million, leaving about \$7 million in unreimbursed costs. Thus, the enhanced payments for these facilities were well in excess of the estimated unreimbursed costs of providing services. The following table reflects the estimated unreimbursed costs per facility compared to the enhanced payments received for FYs 1999 and 2000.

Costs Versus Payments Per Facility

Recipient Facility Number	FY '99 & FY '00 Combined Enhancements	FY '97 & FY '98 Actual Total Costs	Estimated Medicaid Reimbursement	Estimated Unreimbursed Costs	Estimated Excess Enhancements Over Unreimbursed Costs
1	\$10,488,683	\$5,830,058	\$4,372,261	\$1,457,797	\$9,030,886
2	\$7,160,271	\$5,016,695	\$3,990,146	\$1,026,549	\$6,133,722
3	\$12,067,579	\$5,691,401	\$6,137,087	\$(445,686)	\$12,513,265
4	\$13,992,567	\$7,128,494	\$6,707,232	\$421,262	\$13,571,305
5	\$6,616,851	\$3,250,445	\$3,408,982	\$(158,537)	\$6,775,388
6	\$5,708,279	\$5,223,519	\$3,266,178	\$1,957,341	\$3,750,938
7	\$8,469,575	\$5,346,782	\$4,701,293	\$645,489	\$7,824,086
8	\$9,868,696	\$5,785,111	\$5,311,196	\$473,915	\$9,394,781
9	\$9,183,867	\$6,841,068	\$5,194,776	\$1,646,292	\$7,537,575
Total	\$83,556,368	\$50,113,573	\$43,089,151	\$7,024,422	\$76,531,946

As the above figures indicate, we do not believe the enhanced payments were in accordance with section 1902(a)(30) of the Act, which requires the payments to be consistent with efficiency, economy, and quality of care.

Aside from the cost issue, we found no indication that the enhanced payments to the facilities increased the quality of care provided by the recipient facilities. Although they received the payments, it appears that improving quality of care at these facilities was not a goal of the funding mechanism. Based on the design of Alabama's SPA, it gave the appearance that the intent of the enhanced payments was to improve the Medicaid services offered by the public nursing facilities. Therefore, we believe we should have seen more of an outcome at the recipient facilities, reflecting how the Federal funds were used. Instead, the funds lost their identity in the payment and IGT process, and we, as well as State and nursing facility officials, could not determine how the funds were specifically used at the State or local level.

FUNDS NOT RETAINED BY PROVIDERS

The State agency followed a complex formula to draw down additional Federal funding as part of the enhanced payment process and distributed the funds to eligible facilities, giving the appearance that the funds were used by the facilities to provide direct medical care. However, almost all the funds were required to be returned to the State agency, with the facilities keeping only a token share.

The SPA did not specify how the payments were to be transferred to the eligible facilities, nor did it specify how much the facilities were allowed to retain versus how much was to be returned to the State. As part of our review, we attempted to track the dollars transferred between the State and local governments as a result of the nursing home enhanced payments.

The State included the budgeted enhanced payments in the total nursing facilities' expenditures on its budget request to HCFA (HCFA Form 37) and, accordingly, received the Federal share of the enhanced payments along with the Federal share of all other Medicaid expenditures. On the HCFA 37, the State certified that it had the State's portion of the budgeted expenditures available. The State did not require the nursing homes to put up any money to satisfy the requirement that the State provide its share of the expenditures.

The State transferred the enhanced payments, including the State and Federal share, to the eligible nursing facilities on a monthly basis. The facilities receiving the enhanced payments retained 3.5 percent of the payments. Within a few days of receiving the payments, the facilities returned 96.5 percent of the payments to the State agency. State agency officials explained that the percentage retained by the nursing facilities was arrived at via a negotiation process between the State and the nursing facilities. The State issued agreement letters to the nursing facilities citing the agreed-upon percentages.

The following schedule shows the FY 1999 and 2000 facilities' share and State agency's share of these payments.

Facilities' Share and State's Share of Enhanced Payments

Recipient Facility Number	Total Enhancements	Total Returned to State ²	Total Retained by Nursing Homes³
1	\$10,488,683	\$10,121,579	\$367,104
2	\$7,160,271	\$6,909,662	\$250,609
3	\$12,067,579	\$11,645,214	\$422,365
4	\$13,992,567	\$13,502,827	\$489,740
5	\$6,616,851	\$6,385,261	\$231,590
6	\$5,708,279	\$5,508,489	\$199,790
7	\$8,469,575	\$8,173,140	\$296,435
8	\$9,868,696	\$9,523,292	\$345,404
9	\$9,183,867	\$8,862,432	\$321,435
Total	\$83,556,368	\$80,631,896	\$2,924,472

To determine the use of the funds at the local level, we conducted site reviews at two county-owned nursing facilities that received the largest enhanced payments. In both cases, the enhanced payments were deposited into general funds used to pay facility expenses. The funds were not accounted for separately from other funds. We were unable to determine specifically how the funds were used. However, officials at one facility gave us a list of capital expenditures which they indicated could not have been made had they not received the enhanced payments.

We also tried to determine the use of the enhanced payments at the State agency. The 96.5 percent of the payments returned to the State agency was deposited into a special revenue fund. This is the main fund of three funds used by the State to pay Medicaid expenses. Upon deposit, the enhanced payment funds lost their identity. In FY 2000, approximately \$2.1 billion of Medicaid program expenses was paid out of this fund. Under the circumstances, we were unable to determine exactly how the State spent the enhanced payments. However, it is clear that, in effect, the use of the enhanced payments resulted in Federal funds being used to obtain additional Federal funds. Based on the cash outlays from this fund, however, it appears the enhancement payment funds were spent on Medicaid expenditures.

We also asked State agency officials how the funds were used. They were unable to tell us because the payments were commingled with other Medicaid funds.

²Represents 96.5 percent of total enhanced payments.

³Represents 3.5 percent of total enhanced payments.

IMPACT OF IGTs ON MEDICAID PROGRAM

We believe enhanced payments and IGTs have had a dramatic impact on the fiscal integrity of the Medicaid program. Following are three observations for HCFA's consideration relative to any actions being contemplated to provide improved fiscal integrity to the Medicaid program.

Effect of Revising the Medicare Upper Payment Limit Regulations

The new change to the regulations to include a separate aggregate upper limit applicable to payments made to local government owned facilities will significantly limit the funds available to Alabama for enhanced payments to public providers. This regulatory revision creates a separate aggregate limit for local government owned facilities, thereby excluding privately owned facilities from the funding pool computation. We believe this is a much more equitable and reasonable methodology for calculating enhanced payments. Currently, all facilities are included in Alabama's pool, yet only nine facilities benefit from the plan. This grossly inflates the funding pool in relation to the benefitting providers and results in excessive Federal matching outlays.

To demonstrate the effect, in FYs 1999 and 2000, a separate aggregate upper limit applicable to payments made to local government owned facilities would have reduced the funding pools for Alabama from \$83.5 million to \$4.5 million. This would have resulted in a combined 2-year reduction of about \$79 million (Federal share about \$55 million), as shown in the following schedule.

**Potential Payment Reductions
Using A Separate Aggregate Limit for Local Government Owned Providers
(Combined Totals for FYs 1999 and 2000)**

Recipient Facility Number	Actual Enhanced Payments	Revised Payments	Potential Payment Reduction	Federal Share of Payment Reductions
1	\$10,488,683	\$569,653	\$9,919,030	\$6,943,321
2	\$7,160,271	\$407,643	\$6,752,628	\$4,726,840
3	\$12,067,579	\$656,341	\$11,411,238	\$7,987,867
4	\$13,992,567	\$740,048	\$13,252,519	\$9,276,763
5	\$6,616,851	\$372,976	\$6,243,875	\$4,370,713
6	\$5,708,279	\$296,103	\$5,412,176	\$3,788,523
7	\$8,469,575	\$451,159	\$8,018,416	\$5,612,891
8	\$9,868,696	\$531,378	\$9,337,318	\$6,536,123
9	\$9,183,867	\$490,200	\$8,693,667	\$6,085,566
Total	\$83,556,368	\$4,515,501	\$79,040,867	\$55,328,607

Effect of Using Resource Utilization Groups Instead of Costs

The HCFA allows State agencies to use RUGs to calculate the Medicare upper payment limit in determining their enhanced payment pools. The Alabama State agency did not use RUGs, but used cost data from facility cost reports. State officials informed us that they had considered calculating the Medicare upper payment limit using RUGs. For comparison, they completed three different funding pool calculations using RUGs to estimate the Medicare upper payment limit. The only difference in the methodologies was the type of patient considered. One calculation was based on Medicaid patients only (\$129 million), one was based on Medicare patients only (\$341 million), and one was based on all patients (\$176 million). We did not review these estimates in detail or the appropriateness of the RUGs included in the calculations because the State did not actually use them in computing its enhanced payments.

The estimates using RUGs are staggering in comparison to the \$39.5 million and \$44 million calculated by the State agency for FYs 1999 and 2000. In light of these figures, we are concerned about the reasonableness of using RUGs in lieu of using cost report data which are readily available and verifiable on a facility basis. We continue to believe that HCFA needs to define and develop a consistent means of determining how the Medicare upper payment limit should be calculated and that any proposed methodology should exclude the use of RUGs.

Increase in Federal Contributions

Through the enhanced payments and IGTs, the State agency developed a mechanism to receive additional Federal Medicaid funds without committing its share of required matching funds. Consequently, we estimate that the Federal share of nursing home expenditures increased from about 70 percent (Alabama's FMAP percentage) to about 78 percent, thus effectively reducing the State's share by 8 percent.

Generally, the effective Federal share increased as follows. The State initially received approximately 70 percent of Federal matching dollars when it made the enhanced payments to the nursing facilities and reported them as program expenses. When the 96.5 percent of the enhanced payments came back to the State from the nursing facilities, the State used those funds for other Medicaid expenditures. These expenses were reported, and in turn, the State received Federal matching funds. Thus, there was a Federal match on the original enhanced payments and a Federal match on the second use of the enhanced payments. This recycling of the funds had the effect of increasing the overall Federal share.

This recycling effect could be greatly reduced if the State agency were to report the amounts paid back by the nursing facilities as a refund or other collection on the HCFA Form 64, thus offsetting an equal amount previously reported as an expense when the enhanced payments were made to the facilities.

SUMMARY AND RECOMMENDATIONS

Enhanced payments and IGTs have become a financial windfall for Alabama's State agency, and the magnitude of that windfall seems to have unlimited growth potential. We are concerned that we cannot determine the specific use of the funds, but it does appear the funds remained within the confines of the Medicaid program. However, the use of these Federal funds to generate more Federal funds is not the intent for which these funds were provided.

We are more concerned with the financial impact of this program aspect on Federal funds and the lack of controls in place to protect the Federal financial interest. Under current guidelines, we question whether sound fiscal controls, including future financial planning and budgeting, can exist. We believe that HCFA needs such controls to ensure the fiscal integrity of the Medicaid program.

In our draft report, we recommended that HCFA move as quickly as possible to issue regulatory changes involving the upper payment limit calculations. We are pleased to note that HCFA has taken action to change the upper payment limit regulations. On January 12, 2001, HCFA issued revisions to the upper payment limit regulations.

The regulations included several transition periods, one of which applied to Alabama. Using the transition period applicable to Alabama, the financial impact of the new regulations will be gradually phased in and become fully effective on October 1, 2005.

In Alabama, we estimate savings to the Federal Government of about \$44.2 million during the transition period. Once the regulatory changes are fully implemented (i.e., the transition period is passed), we estimate savings to the Federal Government of about \$29.5 million annually, totaling a savings of about \$147.5 million over 5 years (see **APPENDIX B** for additional details). We, therefore, recommend that HCFA take action to ensure that Alabama complies with the phase-in of the revised regulations.

We also recommended that HCFA take additional action to ensure that claims for enhanced payments to Alabama's county-owned facilities are based on financial need and paid directly to the targeted nursing facilities for direct health care services for Medicaid residents.

In addition, we recommended that HCFA address the method of calculating the Medicare upper payment limit. Currently, there is no definitive guidance on how to calculate this limit. If Alabama had used RUGs, as other States have, they estimated that their enhanced payment funding pool would range between \$129 million and \$341 million per year, depending on the methodology used. (Again, we did not review the reasonableness of the estimates or the appropriateness of the use of RUGs in the estimates). Instead, the State used cost report data and its funding pools totaled \$39.5 million in FY 1999 and \$44 million in FY 2000. This broad range of potential funding pool amounts indicates that some clarification is needed to ensure the fiscal integrity of the Medicaid program. We recommended that HCFA should provide the States with definitive guidance on how the upper payment limit should be calculated. We also noted that we believe that the basis of the calculation should be cost report data (i.e., not RUGs).

HCFA's Comments

In general, HCFA noted that States have considerable flexibility in setting payment rates for nursing facility services. However, HCFA has seen an increase in the number of proposals from States that result in excessive payments to individual public facilities. While these types of proposals fit within current rules, HCFA became concerned that there is no commensurate increase in Medicaid coverage, quality, or amount of services provided to Medicaid beneficiaries. Therefore, HCFA has proposed new regulations to close the loophole.

More specifically addressing our recommendations, HCFA agreed that there needs to be a new upper payment limit regulation which creates a separate aggregate upper limit for local government owned providers. On October 10, 2000 HCFA published a Notice of Proposed Rulemaking in which they proposed creating a new upper payment limit for local government providers. This change would significantly reduce the amount of excessive

payments being paid under current regulations. The HCFA's proposal also included a gradual transition policy in order to help States that have relied on upper payment limit financing arrangements.

The HCFA agreed in principle that enhanced payments should be based on the financial need of the facilities and that payments be paid directly to the facilities. However, HCFA stated that it lacks the authority, outside of the regulatory process, to require States to make payments that are reflective of a facility's financial needs. The HCFA also stated that it lacks the resources at this time to propose a new regulation relative to this recommendation but will give it further consideration as resources become available.

Finally, HCFA concurred with our recommendation that it address the method of calculating the Medicare upper payment limit. However, HCFA believes that its existing State plan review process is adequate for ensuring that upper payment limit calculations are reasonable. The HCFA believes that regardless of whether a State uses Medicare prospective payment or cost-based systems to compute the Medicare upper payment limit, creating a separate upper payment limit for local government owned providers will significantly eliminate excessive payments.

OIG's Response

We commend HCFA for its efforts to control excessive enhanced payments currently being made. However, we believe that HCFA's revisions to the upper payment limit regulations do not go far enough in protecting the financial integrity of the Medicaid program.

The HCFA stated that regardless of whether a State uses Medicare prospective payment or cost-based systems to compute the Medicare upper payment limit, creating a separate upper payment limit for local government owned providers will significantly eliminate excessive payments. While we agree the final regulation will reduce excessive payments, we believe it addresses only part of the problem.

There is an area of exposure that we do not believe has been adequately addressed by either the final regulation or HCFA's response: the use of RUGs in calculating the upper payment limit.

Neither HCFA's final regulation nor its response addressed the use of RUGs to calculate the Medicare upper payment limit. Our review indicated in Alabama's case that significant excessive payments would still occur under the newly issued regulation had the State plan amendment specified RUGs (instead of cost report data) as the basis for calculating the Medicare upper payment limit.

As we noted in our report, the State completed three different funding pool calculations using RUGs to estimate the Medicare upper limit. Using the most conservative of the three RUGs categories and the revised regulations, we estimate that the Medicare upper limit for FY 1999 and 2000 combined would have been \$20 million (Federal share \$14 million) as opposed to the \$4.5 million (Federal share \$3.0 million) using cost report data and the proposed regulations. Since we estimated FY 1999 and 2000 combined unreimbursed costs of the eligible facilities to be \$7 million, we believe that a \$20 million Medicare upper limit pool would still result in excessive and unreasonable payments.

Accordingly, we believe that HCFA should require cost report data (instead of RUGs) to be the basis of Medicare upper payment calculations. In addition, to ensure reasonableness of payments and promote economy and efficiency, HCFA should consider the alternative approach of using facility specific upper payment limits.



DEPARTMENT OF HEALTH & HUMAN SERVICES

APPENDIX A

Health Care Financing Administration

DATE: NOV 27 2000

TO: June Gibbs Brown
Inspector GeneralFROM: Michael M. Hash
Acting Administrator

IG	/
EAIG	/
PDIG	/
DIG-AS	/
DIG-EI	/
DIG-OI	/
DIG-MP	/
OCIG	/
ExecSec	/
Date Sent	11-28

RECEIVED
The Administrator
Washington, D.C. 20201

2000 NOV 28 PM 1:13

OFFICE OF INSPECTOR
GENERAL

SUBJECT: Office of Inspector General (OIG) Draft Report: "Review of Medicaid Enhanced Payments to Public Providers and the Use of Intergovernmental Transfers (IGTs) by the Alabama State Medicaid Agency,"
(A-04-00-02165)

Thank you for the opportunity to review and comment on the above-referenced draft report. We appreciate the work OIG is doing in this area. The information that OIG has provided in this draft report is very useful to us as we develop new Medicaid payment policies.

Under current Medicaid requirements, States have considerable flexibility in setting payment rates for nursing facility services. States are permitted to pay in the aggregate up to a reasonable estimate of the amount that would have been paid using Medicare payment principles. This payment restriction is commonly referred to as the Medicare upper payment limit (UPL). This UPL permits States to set higher rates for services furnished in public facilities.

Within the last year, the Health Care Financing Administration (HCFA) has received a number of proposals from States that target payment increases to county and or municipal nursing facilities. The amount of payment is not directly related to cost of services furnished by the facilities, but on the aggregate difference between Medicaid payments and the maximum amount allowed under the Medicare UPL. While these types of proposals fit within current rules, HCFA became concerned when our review found that payments to individual public facilities were excessive, often many times higher than the rate paid private facilities or above the cost incurred by the public facility.

These excessive payments raise serious and troubling policy considerations. The practice appears to be creating a rapid increase in Federal Medicaid spending with no commensurate increase in Medicaid coverage, quality, or amount of services provided to Medicaid beneficiaries. While States claim these payment expenditures are for Medicaid

nursing facility services furnished to an eligible individual, these payments may ultimately be used for a number of purposes, both health care and non-health care related. In many cases, IGTs are used to finance these payments.

On October 10, we proposed regulations to close the loophole in Medicaid regulations that costs Federal taxpayers billions of dollars without commensurate increases in coverage or improvements in the care provided to Medicaid beneficiaries. The proposed regulation would revise Medicaid's "upper payment limit" rules, stopping States from using certain accounting techniques to inappropriately obtain extra Federal Medicaid matching funds that are not necessarily spent on health care services for Medicaid beneficiaries. The changes would be phased in to allow States time to adjust their Medicaid programs to meet the new requirements. In addition, the proposal also would allow a continued higher limit on payments for public hospitals in recognition of their critical role in serving low-income patients. The comment period closed on November 9.

We appreciate the effort that went into this report and the opportunity to comment on the issues raised. Our detailed comments on the OIG's recommendations follow.

OIG Recommendation

HCFA should move as quickly as possible to revise the upper payment limit regulations.

HCFA Response

We concur. In July, we issued a letter to State Medicaid Directors outlining our concerns and informing them of our intent to issue a Notice of Proposed Rulemaking (NPRM). HCFA published the NPRM on October 10. The NPRM invited comment on our proposal to preclude States from aggregating payments across private and public facilities. The proposed regulation would create a new reimbursement limit for local government providers, and in the case of outpatient hospital services and clinic services, an additional upper limit for State-operated facilities. This change would significantly reduce the amount of excessive payments that can and are being paid under the current UPL regulations.

To help States that have relied on UPL financing arrangements, our proposal included a gradual transition policy. Recognizing the need to preserve access by Medicaid beneficiaries to public hospitals and the special expenses incurred by those facilities (e.g., emergency room costs, public health clinics, etc.), we also included provisions to ensure adequate reimbursement rates for such facilities. We have solicited comments on our proposed changes to the UPL policy, as well as the transition provisions, and we are open to other courses of action that will accomplish the same goals set out in the proposed rule.

OIG Recommendation

Pending the national improvements expected through regulatory action, OIG recommends that HCFA take additional action to require that claims for supplementation payments to county owned facilities be based on financial need and paid directly to the targeted nursing facilities for direct health care services for Medicaid residents.

HCFA Response

While we concur in principle with this recommendation, outside of the regulatory process itself we believe we lack the authority to require States to make payments that are reflective of a facility's financial need with respect to services furnished to Medicaid residents. Having to promulgate a new regulation at this time would force us to divert resources away from our current UPL reform initiatives. However, as we indicate above, we are open to other courses of action and will give further consideration to this recommendation, but we believe our current proposal will most immediately curtail excessive spending.

OIG Recommendation

HCFA should address the method of calculating the Medicare upper payment limit.

HCFA Response

We concur. We believe the State plan review process is adequate for us to ensure State estimates are reasonable. When States submit an amendment that may raise an upper payment limit issue, our practice is to require States to provide us a detailed estimate of the Medicare UPL along with the methodology they used to compute the estimate and supporting financial documentation. Our policy does permit States to use Medicare prospective payment or cost-based payment systems to compute the Medicare UPL. Regardless of which approach a State may use, we feel that restricting aggregation of payments between public and private providers will significantly eliminate excessive payments.

APPENDIX B

**SCHEDULE OF FEDERAL SAVINGS IN ALABAMA
BASED ON IMPLEMENTATION OF REVISED UPPER PAYMENT
LIMIT REGULATIONS (INCLUDING TRANSITION PERIOD)**

<u>Fiscal Period</u>	<u>Federal Savings</u> (Millions)
10/01/00 - 09/30/01	\$ 0
10/01/01 - 09/30/02	0
10/01/02 - 09/30/03	7.4
10/01/03 - 09/30/04	14.7
10/01/04 - 09/30/05	<u>22.1</u>
Savings during transition	\$ 44.2
10/01/05 - 09/30/06	\$ 29.5
10/01/06 - 09/30/07	29.5
10/01/07 - 09/30/08	29.5
10/01/08 - 09/30/09	29.5
10/01/09 - 09/30/10	<u>29.5</u>
Five year savings after transition	\$ 147.5